



P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

☎ 0171-2532620, 8222896961 ✉ pkrjainhealthcare@gmail.com

NAME : Mrs. GEETA
AGE/ GENDER : 39 YRS/FEMALE
COLLECTED BY :
REFERRED BY :
BARCODE NO. : 12507956
CLIENT CODE. : P.K.R JAIN HEALTHCARE INSTITUTE
CLIENT ADDRESS : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA

PATIENT ID : 1822195
REG. NO./LAB NO. : 122504080013
REGISTRATION DATE : 08/Apr/2025 09:20 AM
COLLECTION DATE : 08/Apr/2025 10:16AM
REPORTING DATE : 08/Apr/2025 01:34PM

Test Name	Value	Unit	Biological Reference interval
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SWASTHYA WELLNESS PANEL: 1.0

COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	10.4 ^L	gm/dL	12.0 - 16.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	4.25	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	33.2 ^L	%	37.0 - 50.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	78 ^L	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	24.4 ^L	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	31.3 ^L	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	19.3 ^H	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	56.9 ^H	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	18.35	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	112.91	RATIO	BETA THALASSEMIA TRAIT: <= 65.0 IRON DEFICIENCY ANEMIA: > 65.0

WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	6250	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) by AUTOMATED 6 PART HEMATOLOGY ANALYZER	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) %	NIL	%	< 10 %




DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)


DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY)





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by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER			
<u>DIFFERENTIAL LEUCOCYTE COUNT (DLC)</u>			
NEUTROPHILS	53	%	50 - 70
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
LYMPHOCYTES	27	%	20 - 40
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
EOSINOPHILS	8 ^H	%	1 - 6
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
MONOCYTES	12 ^H	%	2 - 12
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
BASOPHILS	0	%	0 - 1
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT	3313	/cmm	2000 - 7500
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE LYMPHOCYTE COUNT	1688	/cmm	800 - 4900
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE EOSINOPHIL COUNT	500 ^H	/cmm	40 - 440
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE MONOCYTE COUNT	750	/cmm	80 - 880
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE BASOPHIL COUNT	0	/cmm	0 - 110
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT)	297000	/cmm	150000 - 450000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELETCRIT (PCT)	0.36	%	0.10 - 0.36
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
MEAN PLATELET VOLUME (MPV)	12	fL	6.50 - 12.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL COUNT (P-LCC)	132000 ^H	/cmm	30000 - 90000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET LARGE CELL RATIO (P-LCR)	44.4	%	11.0 - 45.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
PLATELET DISTRIBUTION WIDTH (PDW)	15.6	%	15.0 - 17.0




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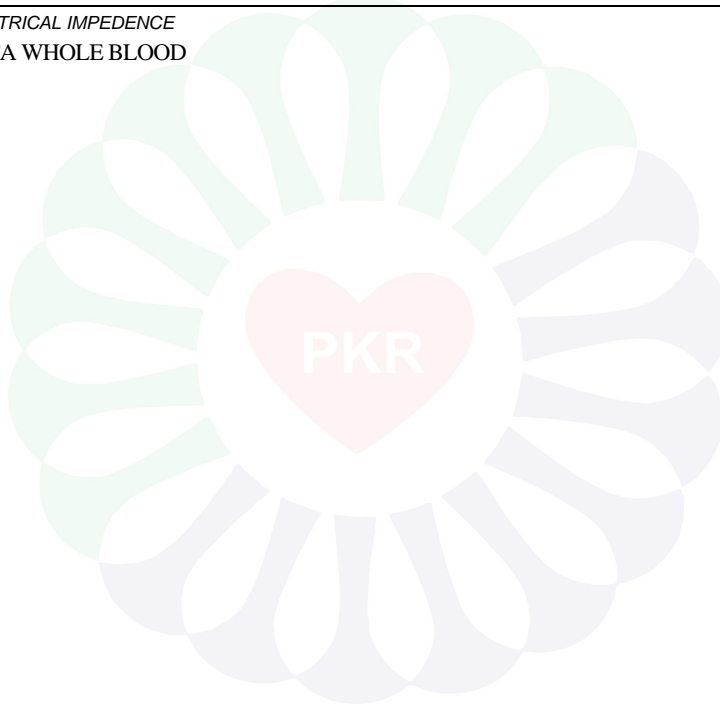
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by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD




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ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR) **46^H** mm/1st hr 0 - 20

by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY

INTERPRETATION:

1. ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and autoimmune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it.
2. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test such as C-reactive protein
3. This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as some others, such as systemic lupus erythematosus

CONDITION WITH LOW ESR

A low ESR can be seen with conditions that inhibit the normal sedimentation of red blood cells, such as a high red blood cell count (polycythaemia), significantly high white blood cell count (leucocytosis), and some protein abnormalities. Some changes in red cell shape (such as sickle cells in sickle cell anaemia) also lower the ESR.

NOTE:

1. ESR and C - reactive protein (C-RP) are both markers of inflammation.
2. Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
3. **CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.**
4. If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen.
5. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations.
6. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while aspirin, cortisone, and quinine may decrease it




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PROTHROMBIN TIME STUDIES (PT/INR)

PT TEST (PATIENT) by PHOTO OPTICAL CLOT DETECTION	17.4 ^H	SECS	11.5 - 14.5
PT (CONTROL) by PHOTO OPTICAL CLOT DETECTION	12	SECS	
ISI by PHOTO OPTICAL CLOT DETECTION	1.1		
INTERNATIONAL NORMALISED RATIO (INR) by PHOTO OPTICAL CLOT DETECTION	1.5 ^H		0.80 - 1.20
PT INDEX by PHOTO OPTICAL CLOT DETECTION	68.97	%	

ADVICE

KINDLY CORRELATE CLINICALLY

INTERPRETATION:-

- 1.INR is the parameter of choice in monitoring adequacy of oral anti-coagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity.
2. Prolonged INR suggests potential bleeding disorder /bleeding complications
3. Results should be clinically correlated.
4. Test conducted on Citrated Plasma

RECOMMENDED THERAPEUTIC RANGE FOR ORAL ANTI-COAGULANT THERAPY (INR)

INDICATION		INTERNATIONAL NORMALIZED RATIO (INR)
Treatment of venous thrombosis	Low Intensity	2.0 - 3.0
Treatment of pulmonary embolism		
Prevention of systemic embolism in tissue heart valves		
Valvular heart disease		
Acute myocardial infarction		
Atrial fibrillation		
Bileaflet mechanical valve in aortic position		
Recurrent embolism	High Intensity	2.5 - 3.5
Mechanical heart valve		



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Test Name	Value	Unit	Biological Reference interval
Antiphospholipid antibodies ⁺			

COMMENTS:

The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the efficacy of the extrinsic pathway of coagulation. PT test reflects the adequacy of factors I (fibrinogen), II (prothrombin), V, VII, and X. It is used in conjunction with the activated partial thromboplastin time (aPTT) which measures the intrinsic pathway.

The common causes of prolonged prothrombin time are :

- 1.Oral Anticoagulant therapy.
- 2.Liver disease.
- 3.Vit K. deficiency.
- 4.Disseminated intra vascular coagulation.
- 5.Factor 5, 7 , 10 or Prothrombin deficiency




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ACTIVATED PARTIAL THROMBOPLASTIN TIME (APTT)

APTT (PATIENT VALUE)	38	SECS	28.6 - 38.2
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by PHOTO OPTICAL CLOT DETECTION

INTERPRETATION:-


The activated partial thromboplastin time (aPTT or APTT) is a performance indicator measuring the efficacy of both the **intrinsic** (now referred to as the contact activation pathway) and the common coagulation pathways. Apart from detecting abnormalities in blood clotting, it is also used to monitor the treatment effects with heparin, a major anticoagulant. It is used in conjunction with the prothrombin time (PT) which measures the extrinsic pathway.

COMMON CAUSES OF PROLONGED APTT :-

1. Disseminated intravascular coagulation.
2. Liver disease.
3. Massive transfusion with stored blood.
4. Heparin administration or contamination.
5. A circulating Anticoagulant.
6. Deficiency of a coagulation Factor other than factor 7.




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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA

112.28^H

mg/dL

NORMAL: < 100.0

PREDIABETIC: 100.0 - 125.0

DIABETIC: > OR = 126.0

INTERPRETATION

IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A fasting plasma glucose level below 100 mg/dl is considered normal.
2. A fasting plasma glucose level between 100 - 125 mg/dl is considered as glucose intolerant or prediabetic. A fasting and post-prandial blood test (after consumption of 75 gms of glucose) is recommended for all such patients.
3. A fasting plasma glucose level of above 125 mg/dl is highly suggestive of diabetic state. A repeat post-prandial is strongly recommended for all such patients. A fasting plasma glucose level in excess of 125 mg/dl on both occasions is confirmatory for diabetic state.



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LIPID PROFILE : BASIC			
CHOLESTEROL TOTAL: SERUM <i>by CHOLESTEROL OXIDASE PAP</i>	98.21	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM <i>by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)</i>	135.81	mg/dL	OPTIMAL: < 150.0 BORDERLINE HIGH: 150.0 - 199.0 HIGH: 200.0 - 499.0 VERY HIGH: > OR = 500.0
HDL CHOLESTEROL (DIRECT): SERUM <i>by SELECTIVE INHIBITION</i>	22.5 ^L	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	48.55	mg/dL	OPTIMAL: < 100.0 ABOVE OPTIMAL: 100.0 - 129.0 BORDERLINE HIGH: 130.0 - 159.0 HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0
NON HDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	75.71	mg/dL	OPTIMAL: < 130.0 ABOVE OPTIMAL: 130.0 - 159.0 BORDERLINE HIGH: 160.0 - 189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0
VLDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	27.16	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	332.23 ^L	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	4.36	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0




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LDL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.16	RATIO	MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0 LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	6.04 ^H	RATIO	3.00 - 5.00

INTERPRETATION:

- Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.
- As per NLA-2014 guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.
- Low HDL levels are associated with increased risk for Atherosclerotic Cardiovascular disease (ASCVD) due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.
- NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lp(a), Chylomicron remnants) along with LDL-cholesterol as co-primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL & Non HDL.
- Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement




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LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	0.58	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.23	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.35	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	135.6 ^H	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	81 ^H	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.67	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	278.92 ^H	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	229.7 ^H	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.63	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.01 ^L	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3.62 ^H	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.83 ^L	RATIO	1.00 - 2.00

INTERPRETATION

NOTE:- To be correlated in individuals having SGOT and SGPT values higher than Normal Reference Range.

USE:- Differential diagnosis of diseases of hepatobiliary system and pancreas.

INCREASED:

DRUG HEPATOTOXICITY	> 2
ALCOHOLIC HEPATITIS	> 2 (Highly Suggestive)
CIRRHOSIS	1.4 - 2.0
INTRAHEPATIC CHOLESTATIS	> 1.5




DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)


DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY)





P K R JAIN HEALTHCARE INSTITUTE

NASIRPUR, Hissar Road, AMBALA CITY- (Haryana)

A PIONEER DIAGNOSTIC CENTRE

☎ 0171-2532620, 8222896961 ✉ pkrajainhealthcare@gmail.com

NAME	: Mrs. GEETA	PATIENT ID	: 1822195
AGE/ GENDER	: 39 YRS/FEMALE	REG. NO./LAB NO.	: 122504080013
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Test Name	Value	Unit	Biological Reference interval
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS		> 1.3 (Slightly Increased)	

DECREASED:

1. Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)
2. Extra Hepatic cholestasis: 0.8 (normal or slightly decreased).

PROGNOSTIC SIGNIFICANCE:

NORMAL	< 0.65
GOOD PROGNOSTIC SIGN	0.3 - 0.6
POOR PROGNOSTIC SIGN	1.2 - 1.6




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CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)


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CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY)





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KIDNEY FUNCTION TEST (COMPLETE)

UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	21.72	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	0.83	mg/dL	0.40 - 1.20
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	10.15	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	12.23	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	26.17	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	7.91 ^H	mg/dL	2.50 - 6.80
CALCIUM: SERUM by ARSENAZO III, SPECTROPHOTOMETRY	10.17	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY	3.8	mg/dL	2.30 - 4.70

ELECTROLYTES

SODIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	143.3	mmol/L	135.0 - 150.0
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	3.99	mmol/L	3.50 - 5.00
CHLORIDE: SERUM by ISE (ION SELECTIVE ELECTRODE)	107.48	mmol/L	90.0 - 110.0

ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM by CALCULATED	91.9
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INTERPRETATION:

To differentiate between pre- and post renal azotemia.

INCREASED RATIO (>20:1) WITH NORMAL CREATININE:

1. Prerenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion, dehydration, blood loss) due to decreased glomerular filtration rate.




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CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)


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CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY)





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- Catabolic states with increased tissue breakdown.
- GI haemorrhage.
- High protein intake.
- Impaired renal function plus
- Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein diet, burns, surgery, cachexia, high fever).
- Urine reabsorption (e.g. ureter colostomy)
- Reduced muscle mass (subnormal creatinine production)
- Certain drugs (e.g. tetracycline, glucocorticoids)

INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS:

- Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy).
- Prerenal azotemia superimposed on renal disease.

DECREASED RATIO (<10:1) WITH DECREASED BUN :

- Acute tubular necrosis.
- Low protein diet and starvation.
- Severe liver disease.
- Other causes of decreased urea synthesis.
- Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).
- Inherited hyperammonemias (urea is virtually absent in blood).
- SIADH (syndrome of inappropriate antidiuretic hormone) due to tubular secretion of urea.
- Pregnancy.

DECREASED RATIO (<10:1) WITH INCREASED CREATININE:

- Phenacimide therapy (accelerates conversion of creatine to creatinine).
- Rhabdomyolysis (releases muscle creatinine).
- Muscular patients who develop renal failure.

INAPPROPRIATE RATIO:

- Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies, resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).
- Cephalosporin therapy (interferes with creatinine measurement).

ESTIMATED GLOMERULAR FILTRATION RATE:

CKD STAGE	DESCRIPTION	GFR (mL/min/1.73m2)	ASSOCIATED FINDINGS
G1	Normal kidney function	>90	No proteinuria
G2	Kidney damage with normal or high GFR	>90	Presence of Protein , Albumin or cast in urine
G3a	Mild decrease in GFR	60 -89	
G3b	Moderate decrease in GFR	30-59	
G4	Severe decrease in GFR	15-29	
G5	Kidney failure	<15	




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CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)


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CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)





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Test Name	Value	Unit	Biological Reference interval
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COMMENTS:

1. Estimated Glomerular filtration rate (eGFR) is the sum of filtration rates in all functioning nephrons and so an estimation of the GFR provides a measure of functioning nephrons of the kidney.
2. eGFR calculated using the 2009 CKD-EPI creatinine equation and GFR category reported as per KDIGO guideline 2012
3. In patients, with eGFR creatinine between 45-59 ml/min/1.73 m² (G3) and without any marker of Kidney damage, It is recommended to measure eGFR with Cystatin C for confirmation of CKD
4. eGFR category G1 OR G2 does not fulfill the criteria for CKD, in the absence of evidence of Kidney Damage
5. In a suspected case of Acute Kidney Injury (AKI), measurement of eGFR should be done after 48-96 hours of any Intervention or procedure
6. eGFR calculated by Serum Creatinine may be less accurate due to certain factors like Race, Muscle Mass, Diet, Certain Drugs. In such cases, eGFR should be calculated using Serum Cystatin C
7. **A decrease in eGFR implies either progressive renal disease, or a reversible process causing decreased nephron function (eg, severe dehydration).**

ADVICE:

KDIGO guideline, 2012 recommends Chronic Kidney Disease (CKD) should be classified based on cause, eGFR category and Albuminuria (ACR) category. GFR & ACR category combined together reflect risk of progression and helps Clinician to identify the individual who are progressing at more rapid rate than anticipated




DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)


DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY)





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IMMUNOPATHOLOGY/SEROLOGY

HEPATITIS C VIRUS (HCV) ANTIBODY: TOTAL

HEPATITIS C ANTIBODY (HCV) TOTAL: SERUM 0.18 S/CO
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)
NEGATIVE: < 1.00
POSITIVE: > 1.00

HEPATITIS C ANTIBODY (HCV) TOTAL
RESULT NON - REACTIVE
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

INTERPRETATION:-

RESULT (INDEX)	REMARKS
< 1.00	NON - REACTIVE/NOT - DETECTED
> =1.00	REACTIVE/ASYMPTOMATIC/INFECTIVE STATE/CARRIER STATE.

Hepatitis C (HCV) is an RNA virus of Favivirus group transmitted via blood transfusions, transplantation, injection drug abusers, accidental needle punctures in healthcare workers, dialysis patients and rarely from mother to infant. 10 % of new cases show sexual transmission. As compared to HAV & HBV , chronic infection with HCV occurs in 85 % of infected individuals. In high risk population, the predictive value of Anti HCV for HCV infection is > 99% whereas in low risk populations it is only 25 %.

USES:

- Indicator of past or present infection, but does not differentiate between Acute/ Chronic/Resolved Infection.
- Routine screening of low and high prevalence population including blood donors.

NOTE:

- False positive results are seen in Auto-immune disease, Rheumatoid Factor, HYpergammaglobulinemia, Paraproteinemia, Passive antibody transfer, Anti-idiotypes and Anti-superoxide dismutase.
- False negative results are seen in early Acute infection, Immunosuppression and Immuno— incompetence.
- HCV-RNA PCR recommended in all reactive results to differentiate between past and present infection.



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CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA

CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)





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Test Name	Value	Unit	Biological Reference interval
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ANTI HUMAN IMMUNODEFICIENCY VIRUS (HIV) DUO ULTRA WITH (P-24 ANTIGEN DETECTION)

HIV 1/2 AND P24 ANTIGEN: SERUM 0.13 S/CO
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY) NEGATIVE: < 1.00
POSITIVE: > 1.00

HIV 1/2 AND P24 ANTIGEN RESULT NON - REACTIVE
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

INTERPRETATION:-

RESULT (INDEX)	REMARKS
< 1.00	NON - REACTIVE
> = 1.00	PROVISIONALLY REACTIVE

Non-Reactive result implies that antibodies to HIV 1/ 2 have not been detected in the sample . This means that patient has either not been exposed to HIV 1/ 2 infection or the sample has been tested during the "window phase" i.e. before the development of detectable levels of antibodies. Hence a Non Reactive result does not exclude the possibility of exposure or infection with HIV 1/ 2.

RECOMMENDATIONS:

1. Results to be clinically correlated
2. Rarely falsenegativity/positivity may occur.



DR.VINAY CHOPRA

CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA

CONSULTANT PATHOLOGIST
MBBS , MD (PATHOLOGY)





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A PIONEER DIAGNOSTIC CENTRE

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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.

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HEPATITIS B SURFACE ANTIGEN (HBsAg) ULTRA

HEPATITIS B SURFACE ANTIGEN (HBsAg): 0.21 S/CO NEGATIVE: < 1.0
SERUM POSITIVE: > 1.0

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

HEPATITIS B SURFACE ANTIGEN (HBsAg) NON REACTIVE
RESULT

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

INTERPRETATION:

RESULT IN INDEX VALUE	REMARKS
< 1.30	NEGATIVE (-ve)
>=1.30	POSITIVE (+ve)

Hepatitis B Virus (HBV) is a member of the Hepadna virus family causing infection of the liver with extremely variable clinical features. Hepatitis B is transmitted primarily by body fluids especially serum and also spread effectively sexually and from mother to baby. In most individuals HBV hepatitis is self limiting, but 1-2 % normal adolescent and adults develop Chronic Hepatitis. Frequency of chronic HBV infection is 5-10% in immunocompromised patients and 80 % neonates. The initial serological marker of acute infection is HBsAg which typically appears 2-3 months after infection and disappears 12-20 weeks after onset of symptoms. Persistence of HBsAg for more than 6 months indicates carrier state or Chronic Liver disease.




DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)


DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY)





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Test Name	Value	Unit	Biological Reference interval
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CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECIEVED	10	ml	
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
COLOUR	AMBER YELLOW		PALE YELLOW
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
TRANSPARANCY	HAZY		CLEAR
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SPECIFIC GRAVITY	1.01		1.002 - 1.030
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			


CHEMICAL EXAMINATION

REACTION	ACIDIC		
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
PROTEIN	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SUGAR	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
pH	<=5.0		5.0 - 7.5
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BILIRUBIN	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
NITRITE	Positive		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.			
UROBILINOGEN	Normal	EU/dL	0.2 - 1.0
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
KETONE BODIES	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BLOOD	TRACE		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

MICROSCOPIC EXAMINATION




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CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)


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CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY)





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Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCs) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	3-4	/HPF	0 - 3
PUS CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	20-25	/HPF	0 - 5
EPITHELIAL CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	4-6	/HPF	ABSENT
CRYSTALS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	ABSENT		ABSENT

*** End Of Report ***




DR.VINAY CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY & MICROBIOLOGY)


DR.YUGAM CHOPRA
CONSULTANT PATHOLOGIST
MBBS, MD (PATHOLOGY)

